A thru Z PEDIATRICS

San Antonio A thru Z Pediatrics, P.A.
1314 E. Sonterra Blvd., Ste. 5102, San Antonio, TX
210-490-8888; 210-496-6865 (fax)

7922 Ewing Halsell, Ste. 360, San Antonio, TX
210-614-7500; 210-614-7540 (fax)

Web: www.a-zpeds.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name (s): _____

DOB: _____

I authorize San Antonio A thru Z Pediatrics, P.A. to release health information regarding the above referenced patient(s) to the following individuals:

Name of Individual	Relationship to Patient

Information authorized for disclosure:

□ Complete Health Record
□ Immunization Records
□ Progress Reports
□ Radiology and Diagnositc Imaging Reports
□ Pathology Reports
□ Laboratory Tests
□ Behavioral Health Services/ Psychiatric Care
□ Drug or alcohol abuse history and/or treatment
□ Infectious or contagious disease information, including HIV/AIDS
□ Sexually Transmitted Diseases
□ Genetic Counseling/Testing

NOTICE

San Antonio A thru Z Pediatrics, P.A. and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep health information confidential. If you have authorized the disclosure of your child's health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

1. I understand this authorization is voluntary.

2. I have a right to revoke this authorization at any time. If I decide to revoke the authorization, I must do so in writing. I can submit this to:

San Antonio A thru Z Pediatrics, P.A.
Attn: Health Information
1314 E. Sonterra Blvd., Ste. 5102
San Antonio, TX 78258

3. I understand that revocation will not apply to information that has already been release in response to this authorization.

4. Unless otherwise revoked, this authorization expires 12 months after the date of signing this form.

I hereby release this facility, its employees, officers, and physicians from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____

Printed Name

_____

Relationship to patient (if other than patient)